

## Summary of the March 17, 2003 System Leadership Council Meeting

The following Council members attended this meeting.

Janet Areson	Larry L. Latham, Ph.D.	James S. Reinhard, M.D.
H. Lynn Chenault	Dean Lynch	Julie A. Stanley, J.D.
Charline A. Davidson	Jules J. Modlinks, Ph.D.	James W. Stewart, III
Gerald E. Deans	James R. Peterson	Frank L. Tetrick, III
James L. Evans, M.D.	George W. Pratt, Ed.D.	James A. Thur, M.P.H.
Paul R. Gilding	Raymond R. Ratke	Joy Yeh, Ph.D.
Nita Grignol		

Howard Cullum attended for Mary Ann Bergeron. James Martinez and Martha Mead also attended the meeting. William Lessard, Stanley Fields, and Manju Ganeriwala from the Department of Medical Assistance Services (DMAS) and Mark Smith and Marty Sellers from Sellers and Feinberg, DMAS consultants, attended to discuss Upper Payment Limits and Intergovernmental Transfers with CSBs.

**1. Agenda and Meeting Summary:** The Council accepted the summary of its January 13, 2003 meeting and adopted the agenda for this meeting as proposed.

### **2. Medicaid Upper Payment Limits and Intergovernmental Transfers with CSBs**

- Manju Ganeriwala distributed and discussed a handout describing the Medicaid Revenue Maximization (Rev-Max) initiative. DMAS proposed this initiative to the Governor, and the General Assembly approved it. The 2002 – 2004 Appropriation Act requires DMAS to generate savings of \$43 million in state general fund savings each year, for a total biennial target of \$86 million, and to work with state and local governments on this effort.
- Rev-Max includes upper payment limits (UPLs) and intergovernmental transfers (IGTs) with government-owned or operated hospitals, nursing homes, clinics, and other providers; administrative claiming with state universities, CSBs, and other agencies; enrolling Medicaid recipients in Medicare; and school projects.
- UPL and IGT activities with CSBs could include three areas: clinic services, community mental health and mental retardation case management, and MR Waiver services.
- She noted that it is critical for the Commonwealth to maximize federal revenue in order to meet budget targets; the revenue potential is significant; and this will be a win-win situation. Participation incentives would be offered as part of the initiative; and she cautioned that if the budget targets were not met, the result could be rate reductions or fewer covered services.
- Marty Sellers distributed and discussed a longer handout about UPLs and IGTs. Medicaid is a federal-state partnership that insures about 44 million low income Americans. Federal financial participation (FFP) varies from state to state, ranging from 50 to 75 percent, and year to year. Virginia's FFP was 51.45 percent in FY 2002, and it is 50.53 for FY 2003. Thus, for each dollar spent on Medicaid services, Virginia receives 50.53 cents from the federal government.
- States have considerable flexibility in how payments are made to providers and the amounts of those payments. Federal law and regulations require that Medicaid payments be efficient and economical; and Medicaid has certain upper payment limits. State Medicaid programs try to keep payments to providers economical without compromising service quality or accessibility.
- He noted that states can gain significant amounts of federal funds for their Medicaid programs and for other purposes by making payments to government-related providers at or near the maximum permissible amounts using intergovernmental transfers (IGTs). When a state provides Medicaid services through public entities that are providers and there is a gap between the reimbursement or payment for services and the cost of services, the state can make extra payments to those public providers through IGTs.
- IGTs move funds from one level of government to another. Federal law permits funds transferred from a public entity to be used as the state share in making federally-matched

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Medicaid payments. This is not permitted for private entities, since this would constitute illegal donations.

- In Virginia, governmental entities own many types of healthcare providers: public hospitals, nursing homes (7), ICFs/MR, IMDs, physician and dental practice plans, managed care organizations (e.g., MCV's HMO), local health departments, and CSBs. It was noted that schools also provide some health care services.
- Marty Sellers then described the steps in a UPL/IGT program. Participating local government entities transfer funds to the Commonwealth, using loans. Healthcare providers owned by these participating local governments are identified as unique for Medicaid payment purposes. The State Medical Assistance Plan is amended to create separate payments for public providers. Supplemental payments to these providers at or near their UPL in amounts equal to the funds transferred are made. These supplemental payments are in addition to the regular payments for the included services, which would remain in place.
- He noted that at least 27 states have used such IGTs to increase their federal Medicaid funding by a total of billions of dollars. However, the federal government has placed increasing restrictions on IGTs, making them more complicated but not eliminating them.
- The UPL is the maximum amount that Medicaid (CMS) will pay for a service. The UPL varies by provider and type of service. For example, for mental health outpatient clinic services provided by CSBs, the UPL would be what Medicare would pay, which is 45 percent higher than the Medicaid rate. This could translate into an additional \$2.5 million. For other services (e.g., case management), the UPL must meet a standard of "reasonableness." He stated that the rate had not increased for this service in a number of years, and that, based on the current amount paid by DMAS for CSB-provided case management (\$93 million), this could translate into an additional \$23 million or \$11.5 in additional FFP. In response to a question, he confirmed that this amount would be in addition to the rate increases in the 2002 Appropriation Act for CSB case management, which raised rates by about \$60 or \$80 per month to \$260 per consumer per month. For MR Waiver services provided by CSBs, the UPL standard is "reasonableness" and overall costs being lower than state facility costs. He suggested that, based on the current \$80 million paid to CSBs for MR Waiver services, an additional \$40 million might be possible. This is based on a pending Wisconsin proposal; a more realistic figure might be \$10 to \$20 million.
- Marty Sellers then described a typical wire transfer example to illustrate how an IGT might work. CSBs would borrow \$23 million in a "one-day transaction" for the additional case management payments, and this would be transferred electronically to the state. DMAS would then make \$23 million of supplemental payments to CSBs for existing case management services, replacing the \$23 million loan. These payments include \$11.5 million of state match (from the transfer) and \$11.5 million of FFP. The remaining \$11.5 million of the transfer is now available to generate part of the DMAS savings identified in the Appropriation Act, less any incentive payments negotiated by DMAS with CSBs.
- Manju Ganeriwala indicated that the Commonwealth would pay any bank fees and provide the necessary agreements, but not legal advice, associated with these IGTs. She indicated that the amount of incentive payments is negotiable. For example, nursing homes received five percent, while participating schools are receiving 50 percent of the savings amount. Joy Yeh stated that a figure between 15 and 25 percent had been mentioned in preliminary discussions with DMAS.
- Jules Modlinski suggested that there might be problems for some CSBs in obtaining local government approvals of such loans. Marty Sellers indicated that it may not be necessary for all 40 CSBs to participate.
- Howard Cullum asked where the rest of the \$43 million in savings would come from, since only about half of it appears to be coming from CSBs. Also, with only four months left in FY 2003, it will be difficult to recover all of the budgeted savings for this year. Manju Ganeriwala responded

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that there are no designated amounts from particular areas. She also indicated that DMAS wants to ensure that estimates of possible savings are conservative and that any proposals have the full approval of the federal government. Finally, she acknowledged that most of the savings will not be realized until FY 2004. She said the Governor was restoring some funds for FY 2003 in amendments that will be presented to the veto session in April.

- She noted that this initiative would become an annual process, renewable each year. Rev-Max participation would be voluntary, and there would not be any penalties for ceasing participation.
- Jim Stewart observed that the original CSB Medicaid initiative in 1991 was very confusing to local governments and this new one looks more complex. He suggested developing a clear, detailed description of how this would work with a hypothetical CSB to help educate local governments. Charline Davidson supported this suggestion. Marty Sellers suggested that the VACSB, VML, and VACO may have a role in explaining the initiative to local government. Jim Stewart suggested an information session for VML and VACO with DMAS and the CSBs.
- George Pratt also supported Jim Stewart's proposal and suggested that the description of the initiative also include the amount of the incentive payment. Jim Peterson noted that local governments could be very supportive of this initiative, given their experience with 4E revenue maximization.
- Howard Cullum asked if one CSB could borrow the entire amount of the IGT. Marty Sellers replied that they would have to examine this idea.
- Jules Modlinski said that addressing liability concerns was more important than how incentive payments would be distributed. Marty Sellers responded that CSB liability was as close to zero percent as possible; liability generally rests with the state.
- Charline Davidson raised concerns about reactions from the private sector, especially regarding MR Waiver services. Marty Sellers replied that if DMAS did not implement this initiative, the alternative would be larger Medicaid cuts that could affect the private sector. Manju Ganeriwala also indicated that successfully implementing this rev-max initiative would be a way to avoid or contain further funding reductions.
- Manju Ganeriwala asked the Council to designate some representatives to work with DMAS, VML, VACO, and DMAS' consultants on this initiative. George Pratt noted that the VACSB Executive Directors Forum will meet the following Tuesday, and he will discuss this initiative with the Forum. Ray Ratke proposed a separate meeting with the Executive Directors about this after the Forum meeting, and George Pratt agreed.
- It was suggested that Howard Cullum and George Braunstein serve as the initial VACSB representatives; ultimately there might be five (one from each region). Howard Cullum noted that the funds have already been taken from DMAS through the budget process, and we need a coherent presentation to gain acceptance for it, otherwise the alternative is additional cuts. He proposed identifying the largest CSBs for inclusion to maximize participation (e.g. eight to 10 CSBs may account for 80 percent of the billing for case management services).
- George Pratt agreed to contact Manju Ganeriwala about this after the Forum meeting.
- He also noted that city managers in southside Tidewater have said they are not going to bail the state out; thus, the incentive payments could be crucial to winning local support.
- Howard Cullum said Medicaid Rev-Max will happen one way or another; we need to set limits on it for our system; there is a need for marketing it to VML and VACO; and, unlike nursing homes, this Rev-Max initiative is in the Appropriation Act, approved by the General Assembly. Ray Ratke noted that, unlike the nursing home IGT, this Rev-Max initiative would retain available funds for human services.

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### 3. Reinvestment and Restructuring Updates

- Charline Davidson distributed copies of two guidance documents, one for the Regional Reinvestment Initiative Implementation Plans, due by April 21, 2003, and the other for the Regional Partnership Planning Process. The first Regional Partnership Report is due in the Department by August 1, 2003. She also distributed a summary of field comments on these documents. The comments urged shorter documents and fewer requirements.
- Howard Cullum said he was still trying to understand how these activities would be integrated into the Governor's budget process. Also, he is concerned about how budget requests other than restructuring would be included in the Governor's budget. He asked for confirmation that restructuring would not be the only input driving the Comprehensive State Plan update.
- Dr. Reinhard and Charline Davidson agreed that restructuring would not be the only input for the Plan update. Ray Ratke noted that the population-specific groups (e.g., forensics, geriatrics, children and adolescents, and dually diagnosed) will be included in it. Charline Davidson noted these other groups are mentioned in the second paragraph of the Regional Partnership Planning Process guidance. She said she did not include other requirements because of concerns about overburdening CSBs.
- Jim Stewart noted that we have jump-started reinvestment, which might otherwise have grown out of restructuring activities. He observed that the types of activities proposed in the Regional Partnership Planning guidance are typically projects that spring up in three to six months. He mentioned that Region IV is using surveys and other processes for its Regional Partnership Planning and suggested that perhaps the real deadline for the report should be August 1, 2004.
- Charline Davidson responded that the August 1, 2003 date is tied to the biennium budget process. Jim Stewart observed that some regions are fully occupied now with their reinvestment projects. He indicated that Region IV is putting all of its energy into reinvestment.
- Jerry Deans suggested that the strategic issue is to substantively include regions in comprehensive planning. He advocated long term strategic planning with ongoing regional dialogue as a continuing theme. Jim Stewart agreed and noted that Region IV has been doing this for the past three or four years with the acute care pilot project.
- Dr. Reinhard asked if the reinvestment projects were exhausting people's desire to do more or energizing them to do more. Frank Tetrick responded that in Region V, energy is low because its reinvestment project has been very intensive, and CSBs are doing everything they can to make it work. He suggested that the process laid out in the Regional Partnership Planning Process guidance will occur naturally in the latter part of the region's implementation of its reinvestment project. He said that the region views the regional partnership as being overlaid on its reinvestment project. He expressed concern that increased focus on the Regional Partnership Planning could lead to a diminished reinvestment project.
- Lynn Chenault observed that each of the seven regions is moving at a different pace, and he suggested that August 1, 2003 could be an interim report. Ray Ratke proposed considering two tracks, regions that are involved in reinvestment projects and those that are not.
- Jerry Deans cautioned that we are drawing a distinction between the reinvestment projects and restructuring activities because of stakeholder concerns about their lack of involvement to date. He reminded everyone that reinvestment is a subset of restructuring.
- Ray Ratke proposed viewing August 1, 2003 as the first report date; the process would continue after that date with a second report due August 1, 2004. The Council endorsed this idea.
- Charline Davidson suggested evaluating this regional partnership approach to determine if it is the best approach for strategic planning beyond the August 1, 2003 to 2004 timeframe.

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- Ray Ratke noted that consumers, family members, private providers, and advocates are knocking on the door to start participating in regional planning processes. Therefore, we need to have some movement of these stakeholders to the table, even recognizing the each region is moving at a different rate.
- George Pratt pointed out that reinvestment involves only mental health services; how are mental retardation and substance abuse stakeholders going to be involved? Charline Davidson responded that each region decides which areas its partnership will address. He asked if it would be acceptable then for Region V to indicate in its August 1, 2003 report that it had focused on mental health reinvestment. She replied that it would be acceptable if that is what the region decided to do. Dr. Reinhard said we realize we will only get a quality product from what the regions choose to do, but other issues also exist, such as geriatric services and the future roles of the various components of the services system.
- Jerry Deans pointed out that other regions may want to address other issues, such as geriatric services.
- Howard Cullum announced his two priorities: a successful reinvestment project and a vehicle for addressing the CSBs' needs in the FY 2004 - FY 2006 biennium budget. In other words, how do CSBs get their budget needs into the process? Charline Davidson replied that the Plan will include the waiting list data submitted by CSBs, but this would not capture any other initiatives.
- Howard Cullum said that the Governmental Relations Committee would be formulating the VACSB's biennium budget request at a special July 18 meeting. Dr. Reinhard suggested that the VACSB submit the request to the Department by August 1, as input for the Plan update.
- Jules Modlinski indicated that his CSB was considering taking over the operation of a private hospital psychiatric unit to address concerns about local inpatient bed shortages. He asked if there were any legal ramifications, for instance related to the state's responsibility for inpatient beds; Dr. Reinhard stated that he was not aware of any. Jim Thur added that the state responsibility relates to funding those beds, rather than operating them. He cautioned Jules Modlinski to be careful not to deficit fund the unit. He indicated he was looking at a similar situation in northern Virginia, and he was not going to bail out the private sector.
- Jim Thur asked when the guidance would be distributed. Charline Davidson replied that it should be out by the end of the week. She indicated she would work with George Pratt and Howard Cullum on how to incorporate the VACSB budget proposals.
- Howard Cullum asked when the quarterly report on reinvestment projects is due to the General Assembly and the Governor. Joy Yeh replied that it was due after the end of the first quarter.

### **4. Reinvestment Project Outcomes**

- Frank Tetrick said he asked for this item to be on the agenda. He reported to the Council that the VACSB had established a group to identify outcomes. He suggested that we needed to take a step back on this and follow the proposed Partnership Agreement process to develop such outcome measures. We should regroup and consolidate our efforts in this area.
- Dr. Reinhard suggested that Frank Tetrick and Jim Martinez coordinate this consolidation. Frank Tetrick noted that the next meeting of the VACSB outcomes group will occur after the VACSB Board Meeting on March 19 at 2:00 p.m. Jim Martinez agreed to attend that meeting.
- Charline Davidson expressed the hope that we will avoid mission creep on this effort, avoiding development of another POMS. Ray Ratke noted that, with the Central Office budget cuts last October, the Office of Research and Evaluation lost some positions and the rest were moved to the program offices. Now, Randy Koch has left, and the Department is considering how to manage the reinvestment outcomes effort. Frank Tetrick suggested that, as the Department sorts this out, CSBs need to be involved.

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### **5. FY 2004 Performance Contract Update**

- Paul Gilding reported on the status of developing the FY 2004 performance contract documents (the contract, the Partnership Agreement, and the General Requirements Document).
- George Pratt mentioned that the VACSB has asked Candace Waller and Jim Stewart to ask George Drumwright to convene the contract negotiating group. Jim Stewart said a letter was coming to Dr. Reinhard about this. Jim Thur observed that probably only one meeting would be necessary.
- Jim Stewart raised concerns about Exhibit A in the contract, e.g., including FTE information. He indicated that he was planting the seed for future changes, so that data more meaningful than unit costs and FTEs can be collected, data that would be more useful for management. He is not expecting changes for the FY 2004 contract, but setting the stage for the contract after that.
- George Pratt observed that we have made significant improvements with the Partnership Agreement. He suggested that, immediately after completion of the FY 2004 contract development, a group get together (probably between May and August) to look at the contract, particularly Exhibit A. Jim Stewart agreed that the Department and CSBs need to identify together to the information that we both need to manage the services system. George Pratt agreed to name CSB representatives; Dr. Reinhard will identify Department representatives.
- Subsequently, the VACSB established a small work group to work with the Department on completing development of the FY 2004 contract documents. This group consists of Gus Fagan, Jim Thur, Lynn Chenault, Jim Stewart, Candace Waller, George Drumwright, Ed Rose (Fairfax County Attorney's Office), Karen Adams (Henrico County Attorney's Office), and John Oliver (Chesapeake County Attorney's Office).

### **6. Allocating Restored/New Funds Appropriated by the General Assembly**

- Joy Yeh distributed spreadsheets on the proposed distribution of the \$2 million of FY 2003 state funds appropriated for substance abuse federal block grant maintenance of effort (MOE) and the \$2.25 million of FY 2004 state funds appropriated for restoration of part of the FY 2003 budget cuts.
- Lynn Chenault asked about the time frame for spending the FY 2003 SA MOE funds. Joy Yeh replied that, as long as the Department has disbursed the funds to CSBs, the money will be considered by the federal government to have been spent for MOE.
- Ray Ratke noted that we will have the SA MOE problem in FY 2004. He suggested that the FY 2004 SA MOE requirements might be met by a combination of possible funds from some reinvestment projects that can be identified as supporting substance abuse services, some funds from the Medicaid rev-max initiative incentive funds, and some CSBs using part of their FY 2004 restoration allocations for substance abuse services. Also, a caboose budget amendment might be sought for FY 2004 SA MOE requirement. Howard Cullum urged the Department to ask for MOE funding in its FY 2004 budget request. Jim Stewart supported this.
- Ray Ratke mentioned that the apparent legislative intent for the \$2.25 million of FY 2004 restoration funds was that the funds be used for mental health services, given appropriations for FY 2003 SA MOE and FY 2004 additional Medicaid MR Waiver slots. Jim Thur concurred that this was the understanding of the advocates.
- Howard Cullum noted that there were no restrictions placed on the use of the FY 2004 restoration funds by the General Assembly. He suggested that the funds should be distributed based on each CSB's percentage of the total FY 2003 budget cut. Ray Ratke noted that the Department did not want to dictate how CSBs should use their FY 2004 restoration funds.
- Jim Stewart also proposed that the FY 2004 restoration funds be allocated to CSBs based on each CSB's percentage of the total FY 2003 budget reduction. Then, each CSB would notify

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the Department of how this figure should be distributed among the three program areas. The Council approved this approach.

- Joy Yeh discussed the non-CSA mandated state funds that CSBs receive. The Department of Planning and Budget (DPB) has indicated that CSBs cannot use these funds as part of their FY 2004 budget reductions that are continued from FY 2003. DPB will ignore any cuts in these funds for FY 2003; but in FY 2004, CSBs must expend their entire allocations or the unexpended balances may be recovered by DPB.

### 7. State Pharmacy Update

- Dr. Evans reported that the task force met last Wednesday. The General Assembly has required a preferred drug list (PDL) by January, 2004. He reviewed the Appropriation Act language. He noted that the language seems to allow for exclusion of mental health drugs. He announced that he will convene a group to begin developing a draft PDL.
- Howard Cullum mentioned that CSBs received a letter from Pat Finnerty about a PDL meeting on March 21 with CSB representatives and DMAS staff.
- Dr. Evans told the Council that the state pharmacy is \$1.1 million over budget for the year; but this is offset by \$1.7 million of med savers returns. Thus, the state pharmacy should end the year with a positive cash flow.
- Dr. Reinhard asked if the state pharmacy being in step with a PDL would be a major problem; Howard Cullum replied that it would not be. If the state pharmacy were not following a PDL, the private sector would complain. He expressed some concern about who should be doing the physician training on the PDL. Dr. Evans indicated training would be done by the clinical subcommittee of the Pharmacy Task Force.

### 8. VOPA Update

- Julie Stanley offered to answer questions. Frank Tetrick asked her to differentiate between the roles of VOPA and the Department's Office of Human Rights. She responded that VOPA's charge is much broader, and VOPA's investigations are completely independent.
- George Pratt asked if there were any formal relationship between VOPA and the Department's human rights and licensing functions. He noted that it would be helpful if there were some kind of interagency agreement between VOPA and the Department. Julie Stanley replied that the Department could not influence when VOPA intervenes, since VOPA's authority comes from federal legislation and regulations. She noted that the memorandum of understanding (MOU) between VOPA and the Department expired in January, 2002.
- Jules Modlinski observed that VOPA brochures have caused confusion among consumers, for example, about reporting abuse and neglect. Julie Stanley noted that CSBs have to report abuse and neglect to the Department within 24 hours, but there is no similar requirement to report to VOPA, except for core licensed facilities (children's residential facilities).
- George Pratt also supported the need for an MOU between VOPA and the Department. Dr. Reinhard and Julie Stanley agreed to look into the possibility of developing an MOU with VOPA.

- 9. Next Meeting and Possible Items for the Next Meeting Agenda:** The Council agreed that its next meeting should be on May 12 from 9:00 a.m. to noon. Possible agenda items include those listed on the agenda for but not covered in this meeting (included in the list below). Jim Stewart asked for a briefing on the Community Consumer Submission (CCS) by the Department's IT staff at the next meeting. Jim Thur asked that the Youth Survey be on a future meeting agenda. **Subsequently, the date of this meeting was changed. The next Council meeting will be on April 28 from 9:00 a.m. to 12:30 p.m. in Conference Room C at Henrico Area Mental Health and Retardation Services.**

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Proposed agenda items for the April 28 meeting.

- CCS Presentation
- FY 2004 Performance Contract Update
- Status on VITA
- Part C Update
- Paperwork/Record Keeping Requirements Reductions
- Federal Medicaid Developments (President Bush's new initiatives, NACBHD and NASMHPD reactions and strategies)
- SA Federal Block Grant Funding Developments (President Bush's new initiatives, expanded Medicaid coverage)